PacificSource HEALTH PLANS

Medical Benefit Summary
Preferred 300+25 VAR

City Of Springfield

Annual Deductible	Per Person, Per Calendar Year	Per Family, Per Calendar Year
All Providers	$300	$900
Out-of-Pocket Limit	**Per Person, Per Calendar Year**	**Per Family, Per Calendar Year**
Participating Providers	$2,500	$5,000
Non-participating Providers	$5,500	N/A

The member is responsible for the above deductible and the following co-pays and co-insurance:

Service	Participating Providers:	Non-participating Providers:
Preventive Care		
Well baby/Well child care	No charge*	20% co-insurance*
Routine physicals	No charge*	20% co-insurance*
Well woman visits	No charge*	20% co-insurance*
Routine mammograms	No charge*	20% co-insurance*
Immunizations	No charge*	20% co-insurance*
Routine colonoscopy	No charge*	40% co-insurance
Prostate cancer screening	No charge*	40% co-insurance
Professional Services		
Office and home visits	$25 co-pay/visit*	$25 copay/visit plus 20% coinsurance*
Specialty office and home visits	$25 co-pay/visit*	$25 copay/visit plus 20% coinsurance*
Office procedures and supplies	No charge*	20% co-insurance*
Surgery	20% co-insurance	40% co-insurance
Outpatient rehabilitation services	20% co-insurance	30% co-insurance
Hospital Services		
Inpatient room and board	20% co-insurance	40% co-insurance
Inpatient rehabilitation services	20% co-insurance	40% co-insurance
Skilled nursing facility care	20% co-insurance	40% co-insurance
Outpatient Services		
Outpatient surgery/services	20% co-insurance	40% co-insurance
Advanced diagnostic imaging	20% co-insurance	40% co-insurance
Diagnostic and therapeutic radiology and lab	20% co-insurance*	40% co-insurance*
Urgent and Emergency Services		
Urgent care center visits	$25 co-pay/visit*	$25 copay/visit plus 20% coinsurance*
Emergency room visits	$100 co-pay/visit plus 20% co-insurance*^	$100 co-pay/visit plus 40% co-insurance^
Ambulance, ground	20% co-insurance	20% co-insurance
Ambulance, air	50% co-insurance	50% co-insurance
Maternity Services		
Physician/Provider services (global charge)	$25 copay/visit*	$25 copay/visit plus 20% coinsurance*
Hospital/Facility services	20% co-insurance	40% co-insurance
Mental Health/Chemical Dependency Services		
Office visits	$25 copay/visit*	$25 copay/visit plus 20% coinsurance*
Inpatient care	20% co-insurance	40% co-insurance
Residential programs	20% co-insurance	40% co-insurance

Other Covered Services		
Allergy injections	$5 copay/visit*	$5 copay/visit plus 20% coinsurance*
Durable medical equipment	20% co-insurance	50% co-insurance
Home health care	20% co-insurance	50% co-insurance
Temporomandibular Joint (TMJ) Services	50% co-insurance	50% co-insurance
Alternative Care and Chiropractic	$25 copay/visit*	$25 copay/visit plus 20% coinsurance*
Transplants	No charge	40% co-insurance

This is a brief summary of benefits. Refer to your handbook for additional information or a further explanation of benefits, limitations, and exclusions.

^ **Co-pay applies to ER physician and facility charges only.** Co-pay waived if admitted into hospital. For emergency medical conditions, non-participating providers are paid at the participating provider level.

* Not subject to annual deductible.

Additional Information

What is the annual deductible?

Your plan's deductible is the amount of money that you pay first, before your plan starts to pay. You'll see on the Medical Benefit Summary that many services, particularly preventive care, are covered by the plan without you needing to meet the deductible. The individual deductible applies if you enroll without dependents. If you and one or more dependents enroll, individual deductibles apply only until the family deductible has been met. Deductible expense is applied to the out-of-pocket limit.

What is the out-of-pocket limit?

The out-of-pocket limit is the most you'll pay for approved medical expenses during the plan year. Once the out-of-pocket limit has been met, the plan will pay 100% of covered charges for the rest of that year. The individual out-of-pocket limit applies only if you enroll without dependents. If you and one or more dependents enroll, individual out-of-pocket limits apply only until the family out-of-pocket limit has been met. Be sure to check your Member Handbook, as there are some charges, such as non-essential health benefits, penalties and balance billed amounts that do not count toward the out-of-pocket limit.

Note that there is a separate category for participating and non-participating providers when it comes to meeting your out-of-pocket limit. Only participating provider expense applies to the participating provider out-of-pocket limit and only non-participating provider expense applies to the non-participating provider out-of-pocket limit.

Payments to providers

Payment to providers is based on the prevailing or contracted PacificSource fee allowance for covered services. Although participating providers accept the fee allowance as payment in full, non-participating providers may not. Services of non-participating providers could result in out-of-pocket expense in addition to the percentage indicated.